STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare	250 W British Flying School Blvd Terrell, TX 75160

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 48923 Based on observations, interviews, and record review the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or quality of life, recognizing each resident's individuality for 2 of 6 residents (Resident #49 and #18) observed for resident rights. - LVN B failed to provide Resident # 18 and Resident #49 with full privacy while performing blood glucose check with insulin administration on 11/20/2024. This failure could place residents at risk of not being treated with dignity and respect. Findings included: Resident #49 Record review of Resident #49's facility face sheet, dated 11/20/2024, reflected Resident #49 was admitted to the facility on [DATE] with a diagnoseis which included hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, type 2 diabetes mellitus with diabetic chronic kidney disease, epilepsy, unspecified, not intractable, without status epilepticus, and acquired absence of right leg below knee ., Record review of Resident #49's comprehensive care plan, dated 8/16/2024, reflected Resident #49 had bowel and bladder incontinence and required incontinent care from staff. Record review of Resident #49's quarterly MDS assessment, dated 8/21/2024, reflected Resident #49 had a BIMS score of 14, which indicated no impaired cognition and was dependent on staff for toileting and accu-checks. During an observation on 11/20/24 at 10:55 AM of a blood glucose check for Resident #49, LVN B entered Resident #49's room to perform blood glucose check. LVN B did not close the entrance door and did not pull the privacy curtain between Resident #49 and Resident#4's roommate, who was also in the room. On the door side of the room, the privacy curtain was not pulled, during care and left Resident #49 exposed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #18 Record review of Resident #18's facility face sheet, dated 11/20/2024, reflected Resident #18 was admitted to the facility on [DATE] readmitted [DATE] with a diagnosies which included: end stage renal disease (kidney can no longer filter waste from your blood), hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease (kidney getting very close to failure or have already failed), diabetes mellitus (increased glucose in the blood) due to underlying condition with diabetic retinopathy (an eye condition that can cause vision loss and blindness in people who have diabetes) without macular edema (swelling in part of the retina (the light -sensitive layer of tissue at the back of your eye), and legal blindness (having central visual acuity of 20/200 or worse in your better eye, even with corrective lenses). Record review of Resident #18's comprehensive care plan, dated 8/16/2024, reflected Resident #18 had bowel and bladder incontinence and required incontinent care from staff. Record review of Resident #18's quarterly MDS assessment, dated 9/27/2024, reflected Resident #18 had a BIMS score of 14, which indicated no impaired cognition and was dependent on staff for toileting and accu-checks. During an observation on 11/20/24 at 11:01 AM of a blood glucose check for Resident #18,. LVN B entered Resident #18's room, the resident was sitting on the wheelchair by the A bed closed to the door., LVN B did not pulled the privacy curtain before checking the blood glucose, blood glucose was 350mg/dl and 10 units of Insulin SQ given to Resident #18's abdomen without pulling the curtain. During an interview on 11/20/24 at 12:42 PM, Resident # 49 said the staff did not usually pulled the privacy curtains. He said he would be embarrassed if someone saw him naked. During an interview on 11/20/24 at 1:50 PM, the DON said every person employed at the facility was responsible for ensuring resident rights and dignity. She said the privacy curtain should always be pulled to provide the resident with full privacy and expected that to occur with each resident encounter during care. She said by not respecting resident rights and dignity it could cause embarrassment if they were exposed during care. During an interview on 11/20/24 at 1:53 PM, the Administrator said resident rights and dignity were the responsibility of every employee. He said during resident personal care like incontinent care the privacy curtain should always be pulled to avoid exposing the resident. He said he expected all staff to maintain dignity for every resident and by not doing so it could cause embarrassment. Record review of the facility policy titled Resident Rights - Dignity and Respect: Revised date 05/2007, 10/2015, Policy: It is the policy of this facility that all residents be treated with kindness, dignity, and respect: Procedures: .Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from passers-by. People not involved in the care of the Resident shall not be present without the resident's consent while they are being examined or treated. Staff members shall knock before entering the Resident's room . Highlights: Dignity and respect, daily activity schedules, privacy, care, and treatments, reporting violations and grievances.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on interviews and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care within 48 hours of a resident's admission, including initial goals based on admission orders, physician orders, dietary orders, and social services for 1 of 18 (Resident #5) reviewed for baseline care plans. -Resident #5 did not have a baseline care plan completed within 48 hours when they admitted on [DATE]. This failure could lead to residents not receiving individualized services and care upon admission. Findings: Record review of Resident #5's face sheet revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Their medical diagnoses included paroxysmal atrial fibrillation (irregular heartbeat), malignant neoplasm of transverse colon (colon cancer), hypertension (high blood pressure), muscle weakness, neuropathy, chronic kidney disease (stage 2, mild), dysphagia (difficulty swallowing), and cognitive communication deficit (difficulty communication due to impaired cognition). Record review of Resident #5's MDS (a resident assessment and care screening form) dated 09/18/2024 revealed a BIMS score (a short interview to determine cognitive status) of 11, indicating mild cognitive impairment. Further review showed that Resident #5 was totally dependent on staff for showering or bathing self and lower body dressing. She also required total assistance for toilet transfers and going from sitting to standing. Resident #5 used a wheelchair at the facility. Record review of Resident #5's Initial Care Plan completed on 9/16/2024 at 3:56pm revealed the following areas were triggered: -cognition: at risk for impaired cognitive function/dementia or impaired thought processes r/t -ADLs: ADL Self Care Performance Deficit r/t, will maintain current level of function in bed mobility, transfers . toilet use and personal hygiene -Infection: has infections and maintain standard precautions when providing resident care Record review of Resident #5's care plan dated 10/07/2024 revealed a focus area of: -Resident #5 has actual impairment to skin integrity and will be free of injury through the review date, with interventions including: encouraging good nutrition and hydration in order to promote healthier skin, monitor/document location of skin injury, report abnormalities, failure to heal, s/sx of infection, and use Enhanced Barrier Precautions. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN G on 11/21/2024 at 9:43am, who was the MDS Nurse, she said that an RN would initiate the baseline care plan for new admitting residents and the MDS Nurses would then approve the plan. In an interview with the DON on 11/21/2024 at 10:25am, she said that nursing staff were usually doing conference meetings with residents to go over their baseline care plans and go over what the residents want and have a plan with them. The DON said there was not much risk to residents not having a baseline care plan within 48 hours since nurses know what residents need related to care and aides know about what diets and orders they have. The DON said that she could see how preferences could be important when having a care plan within a specific timeframe as it related to resident care. The DON said she was shocked that Resident #5's baseline care plan wasn't completed within the allotted timeframe since nursing management go over resident plans every morning. In an interview with CNA N on 11/21/2024 at 1:19pm, she stated that the nurses would tell her how to care for a resident and other important things to keep in mind based on their care plan. She said in addition to the care plan, the DON will communicate to CNAs what a resident wants. Record review of the Resident Assessments policy last reviewed January 2022, it stated that residents will be assessed, and findings documented in their clinical record and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on observations, interviews, and record review, the facility failed to develop comprehensive care plan within seven days after completion of the comprehensive assessment, for one (Resident #52) of 18 residents reviewed for comprehensive care plans as evident by: The facility failed to ensure that Resident #52's care plan was updated to address her blood pressure medications. This failure could place residents on high blood pressure medication at risk for not getting the therapeutic value of their mediations. Findings Included: Record review of Resident #52's face sheet dated 11/20/2024 revealed she was a 67- year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's diseases , COPD (difficulty breathing) , hypertension (high blood pressure), hypotension (low blood pressure), anxiety disorder (worry or fear), hyperlipidemia (high levels of fat in the blood), protein calorie malnutrition (inadequate amount of protein and calories to meet nutritional needs), gastro esophageal reflux disease (heart burn), Emphysema (enlargement of air spaces in the lungs), and Type 11 diabetes (high blood sugar). Record review of Resident #52's Quarterly MDS dated [DATE] revealed she had a BIMS score of 10 which meant minimum cognitive impairment. Record review of Resident #52's quarterly MDS revealed the resident needed minimum assistance with ADLs and was incontinent of bowel and bladder. Record review of Resident #52's physician consolidated orders dated November 2024 revealed an order for Midodrine 10mg by mouth two times a day. Hold if SBP was greater than 130 and DBP greater than 90. Amlodipine 5 mg by mouth one time a day. Hold if SBP was less than 110 and DBP was less than 60. Record review of Resident #52's care plan initiated 5/30/2024 and last updated/revised 10/26/2024 revealed no documentation that the resident was care planned for Midodrine for hypotension and Amlodipine for hypertension. Observation on 11/19/2024 at 1:30 pm revealed Resident #52 was in bed; she was clean and groomed with no offensive odor. She was alert and oriented with some confusion but could make her needs known. In an interview with Resident #44 on 11/19/2024 at 1:30pm she said she was not abused or neglected. She said her only problem was that she did not get her medication for sleep on time the previous night. In an interview on 11/21/2024 at 3:30pm with MDS Coordinator J she said care plans were updated when there were changes in a resident's condition or medications. She looked at Resident #52's care plan and said the care plan did not address Resident #52's blood pressure medications. She said that she was going to update the care plan to address Resident #52's blood pressure medications . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Resident Assessments policy last reviewed January 2022, it stated that residents will be assessed, and the findings documented in their clinical record and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678 Based on interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 18 residents (Resident #16) reviewed for pharmacy services. ADON A failed to follow physician's orders when Resident #16's blood pressure was above the prescribed parameters for November 2024. This failure could lead to residents being prescribed medications without indication and placed residents who required blood pressure monitoring at risk of not receiving the care and services ordered by the physician which could lead to a decrease in their overall health. Findings included: Record review of Resident #16's face sheet dated 11/19/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included essential hypertension. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #16 had a BIMS score of 15 which indicated cognition was intact. She had a diagnosis of hypertension. Record review of Resident #16's care plan dated 11/20/24 did not show any interventions for hypertension. Record review of physician orders dated November 2024 indicated Resident #16 was prescribed Midodrine HCL oral tablet 10 mg three times daily for hypotension. Hold if SBP greater than 130 or DBP greater than 70. Record review of the MAR dated November 1 -19, 2024 indicated on the following dates and times Resident #16 was administered midodrine 10 mg: 11/01/24 at 6:00 a.m., B/P (blood pressure) was 124/88, 11/03/24 at 6:00 a.m., B/P was 106/74, 11/05/24 at 6:00 p.m., B/P was 140/80, 11/09/24 at 6:00 a.m., B/P was 121/72, 11/18/24 at 6:00 a.m., B/P was 124/83, 11/18/24 at 12:00 p.m., B/P was 139/72. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #16 on 11/19/24 at 9:28 AM, she said she did not sleep well last night because her blood pressure was high. Resident #16 said the medication that was given to her yesterday may have caused her blood pressure to rise. She said the facility was able to regulate her blood pressure and she did not have to go to the hospital. Record review of the nurse's notes for Resident #16 dated November 1 through November 19th, 2024, gave no indication of notifying the physician when blood pressure medication was administered outside of the parameters. Interview with the DON on 11/19/24 at 3:21 pm, she said ADON A administered the medication outside the parameters. ADON A notified the physician but did not document it. The DON stated the physician has seen elevated blood pressure for Resident #16 after she smoked. Interview with ADON A on 11/21/24 at 10:00 am, she had worked at the facility for 3 years. ADON A said she was the nurse on duty on 11/18/24 when she administered the midodrine. She said the physician was in the facility that day and she verbally asked him if she could give Resident #16 her medication because she was outside of the required parameters. ADON A said she did not think to put a note in Resident #16's chart when she had the medication cart. She said the risk could be it could give the next shift an unclear assessment and Resident #16's BP could have elevated even more. ADON A said the expectation was the Med-Aides administer medications and notify the charge nurse to update the records. She said the ADONs check charts to see if there was anything to follow-up on for the residents. Interview with the DON on 11/21/24 at 10:20 am she stated she had worked at the facility since 2/16/23. She said the expectation was when the BP was outside of parameters was to report it to the nurse on duty and the nurse would call the physician. The DON said the risk to the resident was the blood pressure would continue to rise and result in hospitalization or use extra medication to bring the BP down. Record review of the facility's Physician Orders policy last reviewed August 2023, it stated that it is the policy of the facility that drugs shall be administered only upon the order of a person duly licensed and authorized to prescribe such drugs and in accordance with the resident's plan of care. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. Record review of the Medication Administration policy, not dated, read in part . it is the policy of this facility to accurately prepare, administer, and document oral medications .take vital signs if required, hold drugs if indicated .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview and record review, the facility failed to ensure each resident's drug regimen be free from unnecessary drugs without adequate indications for its use for 1 of 18 (Resident #2) reviewed for unnecessary medications. -The facility failed to have a medical diagnosis for Resident #2 before he was prescribed Lantus Subcutaneous Solution 100 Unit/ML from 05/28/2024 to 06/04/2024. This failure could lead to residents being prescribed medications without indication and place residents at risk of unnecessary side effects and a decline in overall health. Findings included: Record review of Resident #2's face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Their medical diagnoses included: dementia, hypertension (high blood pressure), muscle weakness, dysphagia (difficulty swallowing), pain in right hip, syncope and collapse (fainting), and unsteadiness on feet. Record review of Resident #2's Quarterly MDS dated [DATE] revealed a BIMS score of 8, indicating moderate impaired cognition. Further review showed Resident #2 required set up or clean-up assistance for oral hygiene, eating, upper and lower body dressing, and personal hygiene. Resident #4 required supervision with showering or bathing self. Resident #2 was total independent or most transfers except for shower transfers where he required setup or clean-up assistance. Record review of Resident #2's comprehensive care plan revealed Resident #2 was resistive to care r/t Dementia and refused showers, skin assessments and weights. He had a goal of cooperating with care through the next review date and interventions which included educating resident/family/caregivers of the possible outcomes of not complying with treatment of care, encouraging as much participation/interaction by the resident as possible during care activities, and praise when behavior is appropriate. Further review showed no care plan areas related to diabetes or refusing labs. Record review of Resident #2's Medical Diagnoses since admission revealed no diagnosis of Type 2 Diabetes Mellitus. Record review of Resident #2's hospital visit before admission on 09/11/2023 revealed no diagnosis of Type 2 Diabetes Mellitus. Record review of Resident #2's physician notes revealed: -On 5/27/202, MD A saw Resident #2 and wrote, He is seen today for a skilled visit. His blood sugars have been elevated. He is on sliding-scale insulin. We are going to start him on Lantus 7 units daily. We will reassess blood sugars in the next visit. He denies any acute complaints today. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/03/2024, MD A saw Resident #2 and wrote, He is seen for a follow-up of diabetes. We started him on insulin at the last visit. I was notified by nursing that he had refused insulin and blood sugar tracks . He does not believe he has diabetes. I spoke with him today and I informed him based on his recent labs that the patient is diabetic and that we are recommending insulin at this time. -There were no other physician notes mentioning elevated blood sugars or diabetes. Record review of Resident #2's MAR dated May and June 2024 revealed he was ordered Lantus subcutaneous (injection given under the skin) Solution 100 Unit/ML and to inject 7 units subcutaneously one time a day for dm (diabetes mellitus) with an Order start date of 5/28/2024 and a Discontinued date of 06/04/2024. Resident #2 refused insulin seven times from 05/29/2024 to 06/04/2024. Record review of Resident #2's lab history revealed one lab on 09/11/2024 which revealed an A1C level (test used to measure high blood sugar) of 5.4% which was within the normal limits of 3.9 to 5.9. There were no other labs in Resident #2's record. In an interview with LVN G on 11/21/2024 at 9:43am, she was the MDS Nurse, LVN G stated that doctors would give facilities a diagnosis and either the nurse or the MDS nurse would add the diagnosis right away into the system. She said MDS nurses were not the ones entering in medication into the system. LVN G was requested to locate Resident #2's Type 2 Diabetes Mellitus diagnosis but was unable to provide it. In an interview with the DON on 11/21/2024 at 10:25am, she stated that when Resident #2 was prescribed Lantus, the facility was not getting physician notes in a timely manner, so they were unable to catch that the resident was prescribed Lantus without an associated diagnosis. She stated that if they did, they would have caught it. The DON said there was no real risk she could see to the resident getting Lantus without a diagnosis because his nurses would have checked his blood sugars before administering insulin and would have contacted his doctor with any issues or concerns. She also said all of Resident #2's labs would be in the system as the facility had merged paper and electronic copies of labs the previous year. Interview with Resident #2 on 11/21/2024 at 10:57am, he stated that he was educated on diabetes, insulin, and the risks of refusing treatment with MD A and that Resident #2 refused further insulin since he never had and did not have diabetes. Interview with MD A on 11/21/2024 at 11:35am, MD A said that Resident #2's blood sugars were high back then and that they were elevated so MD A started him on insulin. MD A said he educated Resident #2 on diabetes and how having it can affect the heart, kidneys, nerves, and other risks but that the resident was adamant that he didn't have it and said he will live with the consequences. MD A said typically when ordering Lantus and other medications, there had to be a diagnosis, since you can't order any medication without stating a diagnosis. MD A did not know why there was no diagnosis in Resident #2's medical records but that since Resident #2 refused it, the diagnosis would not show up. MD A also said that he didn't know if Resident #2 made dietary changes instead, but his numbers were better now. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN L on 11/21/2024 at 1:46pm, he stated that MD A assessed Resident #2 for diabetes and started the resident on Lantus but Resident #2 claimed he was not diabetic so the facility discontinued the order. LVN L said he cannot give medications without a diagnosis, but unsure why there was no diagnosis in Resident #2's medical records. LVN L said all of Resident #2's labs should be in the resident's records and the facility switched to keeping digital records so there was no paper copy . He said if there is no labs in Resident #2's record, it means the resident did not do them as he had a history of refusing blood draws for labs. Interview with RN A on 1/21/2024 at 1:50pm, he stated that residents should have a diagnosis corresponding to their medications. RN A said insulin should only be used for diabetes. RN A stated he worked a different hall so he did not work with Resident #2. RN A said all labs should be in the resident's medical record and that the facility transferred all paper copies of labs to the digital system so it's all there.

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Windsor Rehabilitation and Healthcare	250 W British Flying School Blvd Terrell, TX 75160

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, dispensing, and administering of all drugs and biologicals) to meet the needs of 2 of 6 residents (Resident #75 and Resident #2) reviewed for pharmacy services with 3 errors out of 30 opportunities from 2 of 2 staff (MA C and MA E) and a medication error rate of 10%. 1. The facility failed to ensure MA A administered the correct dosage of Candesartan tab 32 mg 1 po (medicine used to treat hypertension, systolic hypertension, left ventricular hypertrophy and delay progression of diabetic nephropathy) and Claritin-D 24 Hour Oral Tablet Extended Release 24 Hour , d+[DATE] MG (Loratadine &Pseudoephedrine = medicine used to relieves common allergy symptoms such as sneezing, runny nose, itchy, watery eyes and itchy nose or throat, plus sinus congestion and pressure, and nasal congestion all day) per physician orders for Resident #75. 2. MA B failed to administer the following medication for Resident #2' Autologous Serum Eyedrops (a treatment for dry eyes that are made from a patient's own blood) as ordered by the physician. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health. Findings included: 1. Record review of Resident #75's face sheet dated [DATE] revealed the resident was admitted to the facility on [DATE], diagnoses included: acute kidney failure, essential (primary) hypertension (high blood pressure), dementia (c changes in thinking, remembering, and reasoning in a way that affects daily life and activities), unspecified severity, without behavioral disturbance, psychotic disturbance (a group of symptoms that indicate a severe mental disorder that causes a person to lose touch with reality), mood disturbance, and anxiety, osteoarthritis (is a chronic disease that occurs when the cartilage in joints breaks down, causing bones to rub together, this can lead to pain, stiffness, swelling, and the formation of bony spurs)., depression (a serious mood disorder mood disorder that can impact how a person feels, thinks, and acts. It can cause a persistent feeling of sadness and loss of interest in activities that were once enjoyable), and malignant neoplasm (abnormal tissue growth or tumor, that is cancerous and can spread to other parts of the body). Record review of Resident#75's admitted MDS assessment dated [DATE] revealed a BIMS score of 14, which indicated the resident was not cognitively impaired. It also revealed the resident needed total care assist with ADLs with two staff assistance. Observation on [DATE] at 9:47 AM during medication administration with MA C for Resident # 75. MA C was observed preparing and administering Resident # 75's medications by giving Resident #75 Candesartan tab 32 mg 1 tablet and Allergy relief (Loratadine) 10 mg 1 tablet with other medication by mouth. Record review of Resident #75's physician's order summary report revealed the following orders: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. order dated [DATE] Candesartan Cilexetil Oral Tablet 32 MG, (Candesartan Cilexetil) Give 1 tablet by mouth one time a day for HTN. Hold for SBP < 110 or Pulse < 60 and was discontinued [DATE]. . New order dated [DATE] Candesartan Cilexetil Oral Tablet 8 MG (Candesartan Cilexetil) Give 1 tablet by mouth one time a day for HTN Hold for SBP < 110 or Pulse < 60. . order dated [DATE], Claritin-D 24 Hour Oral Tablet Extended Release 24 Hour ,d+[DATE] MG (Loratadine &Pseudoephedrine) Give 1 tablet by mouth one time a day for Allergy symptoms. Record review of Resident #75's MAR for [DATE] revealed Candesartan Cilexetil Oral Tablet 8 MG (Candesartan Cilexetil) Give 1 tablet by mouth one time a day for HTN Hold for SBP < 110 or Pulse < 60. Record review of Resident #75's MAR for [DATE] revealed Claritin-D 24 Hour Oral Tablet Extended Release 24 Hour ,d+[DATE] MG (Loratadine &Pseudoephedrine) Give 1 tablet by mouth one time a day for allergy symptoms. In an interview with MA C on [DATE] at 4:21PM regarding Candesartan (Cilexetil) wrong dose given to Resident #75, she said it was her fault she did not check the dosage and was very sorry and also for not giving Claritin -D24 was always look at the parenthesis of Loratadine and that was why she giving Resident #75's her Loratadine. MA A said she did not think the facility had Clarintin-D24, she would let the DON know. MA C said not giving the right medication and right dosage could result in the resident's medication not working as it was supposed to and she would be more careful checking medication. MA C said she had in-services on medication administration. Observation of MA C's medication cart revealed Candesartan 8mg blister packet intact and Candesartan 32 mg blister rubber band together. 2. Resident #2 was admitted on [DATE] and was readmitted on [DATE] with the diagnoses: vascular dementia (a condition that affects the brain's ability to think, remember, and behave, caused by poor blood flow to the brain) unspecified severity, other recurrent depressive disorders, hyperlipidemia (high fat in the blood), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormones), anemia (when your body does not have enough healthy red blood cells or they do not function properly), bilateral blepharitis eyelid (a common eye condition that causes inflammation of the eyelids, resulting in redness, irritation, and itchiness), keratoconjunctivitis sicca (a condition that causes inflammation of the cornea and conjunctiva due to a lack of tears), not specified as Sjogren's (an autoimmune disorder in which the system that normally fights infection and disease in the body mistakenly attacks its own healthy tissues), bilateral presence of intraocular lens, age-related nuclear cataract, right eye, central corneal ulcer need for assistance with personal care personal history of (healed) traumatic, fracture, overactive bladder, other abnormalities of gait and mobility, memory deficit following cerebral infarction, and dysphasia following cerebral infarction. Record review of Resident# 2"s quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 which indicated moderately impaired cognition. It also revealed the resident needed total care assist with ADLs with two staff's assistance. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's physician's order summary report revealed the following order: . order dated [DATE] Autologous Serum Eye drops 50% 1 drop both eyes QID while awake. Family was to provide medication. Record review of Resident #2's MAR for [DATE] revealed Autologous Serum Eye drops 50% 1 drop both eyes QID, while awake. Family was to provide medication. In an interview with MA E on [DATE] at 4:40 PM regarding the Autologous serum eyedrop that was not administered to Resident # 2, MA E stated and it was initialed as given. MA E said she gave it earlier and she had the medication in the refrigerator in the medication room in a cup. The medication room refrigerator was checked with MA E and RN A and there, the medication was found. Interview with Resident #2 on [DATE] at 4:50 PM she said, she did get her 2nd eye drop and she was not getting her 2nd eye drop at all. Telephone interview with the Pharmacist on [DATE] at 5:11 PM, she said Autologou serum eyedrops 50% 1 drop both eyes QID. She said Autologou was picked up on [DATE] and it should be expired after 90 days. She said the medication had no preservation when opened, and it could cause infection. In an interview with the DON on [DATE] at 10:10 AM, regarding why the MA C had the errors,. the DON said it was shocking., She said MA C was OCD (obsessive compulsive disorder) about these things. She said the ADON might need to pull medications after they were d/c, since that should've been the nurses responsibility. She said they had the pharmacist audits monthly and she didn't know why it didn't get caught. The DON was asked at the point what system the facility had in place for changing dose/gave wrong dose or d/c doses? The DON said d/c doses or changed dose medication should be put in medication room. She said they had pharmacy audits and didn't know why it didn't get caught during the audit. DON said for Claritin error, she thought they didn't have it but it was on the MAR and the facility had Claritin in the building. She said MA C did check the medication room for Claritin and eye drop for Resident#2. The DON said, the ADON went and checked the medication room and saw the packet for eye drops and saw the highlighted part with start date of [DATE] and a white thing/sticker that says discard after this date and it seemed to be conflicting dates. And the resident's family goes to Dallas for the resident's doctor's appointment so that shouldn't have happened since the family was crazy about the resident's medications. The DON said Resident #2 was alert and knows when she doesn't get her medications so it's was shocking that she wasn't getting it. Resident #2's daughter has camera in her room and see if the eye drops was given, and I tried calling the daughter to check the camera but she didn't pick up so she left a voicemail and will try again. The DON said her expectation was for the MA to have the MARs on the cart and check every medication, and make sure the staffs were giving the right medication of Claritin for example and doing more training. The DON said, they have been doing training. Med aides get yearly check off, but they need to implement some more check off throughout the year. She said they also have spot checks, but we will need to do more checks. Record review of the facility's policy titled Physician orders dated Revised ,d+[DATE]: Policy: It is the policy of this facility that drugs shall be administered only upon the order of a person duly licensed and authorized to prescribed such drugs. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It is the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care: Procedures .6. Medication, treatment, or related procedure orders are transcribed in the medical record accordingly. 7. Orders for medications must include: Name and strength of the drug; Quantity or specific duration of therapy; Dosage and frequency of administration; Route of administration if other than oral;, and Reason or problem for which given.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on observation, interview, and record review, the facility must ensure residents were free of any significant medication errors for two (Residents #44, and #52) of eighteen residents reviewed for medications. - The facility failed to follow physician's orders by administering blood pressure medications when Resident #44 and Resident #52's blood pressure were out of the prescribed parameter that it should be held. These failures could place residents at risk of not getting the therapeutic outcomes of their blood pressure medications, that could caused, increased negative side effects, and decline in health status. Findings Included Resident #44 Record review of Resident #44's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included lack of coordination (impaired balance), muscle weakness (decreased strength in the muscle), dementia (memory loss), seizures (uncontrolled jerking), depression (mental illness), psychotic disorder (a mental disorder that disconnect from reality), hypertension (high blood pressure), and schizophrenia (disorder that affects a person's ability think, feel, and behave clearly). Record review of Resident #44's Quarterly MDS dated [DATE] revealed she had a BIMS score of 11 which meant minimum cognitive impairment. Further review of Resident #44's quarterly MDS revealed the resident needed minimum assistance with ADLs and was incontinent of bowel and bladder. Observation on 11/20/2024 at 12:45pm revealed Resident #44 in the dining room eating his lunch. Resident was alert and oriented with some confusion. He was self-fed. In an interview with Resident #44 he was not abuse or neglected. He said said he had no issues with his medications. Record review of Resident #44's physician consolidated orders dated November 2024 revealed an order for carvedilol 3.125 mg by mouth two times a day. Hold if SBP was less than 130 and DBP less than 70 and heart rate less than 60. Record review of Resident #44's November MARs revealed that on the following Carvedilol 3.125mg was not held as ordered by the physician. 11/01/2024 in the AM the resident's blood pressure was 128/88. 11/13/2024 in the AM the resident's blood pressure was 113/71. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/16/2024 in the AM the resident's blood pressure was 117/64. 11/18/2024 in the AM the resident's blood pressure was 122/68. 11/04/2024 in the PM the resident's blood pressure was 125/68. 11/05/2024 in the PM the resident's blood pressure was 120/73. 11/08/2024 in the PM the resident's blood pressure was 127/84. 11/11/2024 in the PM the resident's blood pressure was 121/66. 11/16/2024 in the PM the resident's blood pressure was 121/70 11/18/2024 in the PM the resident's blood pressure was 117/67 In an interview on 11/21/2024 at 12:20pm with Medication Aide C she said that she was not the one who gave Resident #44 his medication on the dates when they were documented as not held. She said if there was no indication on the MARs that the medication was held or it was given then it would be hard to say it was not given or it was given. She said if a medication was given when it was to be held it could cause the blood pressure to drop lower and the resident could pass out. In an interview on 11/21/2024 at 12:25pm with RN A he said when medications were given it should be documented on the MARs. He said if medications have parameters in which they should be held, then they should document on the MARs with a number. He said if blood pressure medications were not held when it was to be held then it could cause the resident's blood pressure to drop lower and the resident could get dizzy and passed out. He said his expectations of Med Aides were to follow the physician's order and inform the nurse when blood pressure was too low. He said if the Med Aide reported low blood pressure to him, he would recheck the blood pressure and based on the result he would inform the physician. Resident #52 Record review of Resident #52's face sheet dated 11/20/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's diseases , COPD (difficulty breathing) , hypertension (high blood pressure), hypotension (low blood pressure), anxiety disorder (worry or fear), hyperlipidemia (high levels of fat in the blood), protein calorie malnutrition (inadequate amount of protein and calories to meet nutritional needs), gastro esophageal reflux disease (heart burn), emphysema (enlargement of air spaces in the lungs), and Type 11 diabetes (high blood sugar). Record review of Resident #52's Quarterly MDS dated [DATE] revealed she had a BIMS score of 10 which meant minimum cognitive impairment. Record review of Resident #52's quarterly MDS revealed the resident needed minimum assistance with ADLs and was incontinent of bowel and bladder. Observation on 11/19/2024 at 1:30 pm revealed Resident #52 was in bed; she was clean and groomed with no offensive odor. She was alert and oriented with some confusion but could make her needs known. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #52 on 11/19/2024 at 1:30pm she said she was not abuse or neglected. She said she did not have any problems with her medication. Record review of Resident #52's physician orders dated November 2024 revealed order Midodrine 10mg by mouth two times a day. Hold if SBP was greater than 130 and DBP greater than 90 and heart rate less than 60. Record review of Resident #52's November MARs revealed that on the following dated Midodrine 10mg was not held as ordered by the physician. 11/02/2024 in the AM the resident's blood pressure was 133/72. 11/12/2024 in the AM the resident's blood pressure was 140/56. In an interview on 11/21/2024 at 11:48pm with LVN L he said that the medication aides should not give medication when it was supposed to be held. He said that if the medication was held too frequently, the expectation of the medication aides were to let the nurse know and they would call and inform the doctor about the medication to see what he wants to do. In an interview on 11/21/2024 at 12:05pm with Med Aide E she said she usually reported to the nurse when the blood pressure medication was to be held and document it on the MARs. She said she did not know what happened, why she did not indicate on the MAR's that the medication was held. She said that if the blood pressure medication was not held when it was supposed to be held it could cause the blood pressure to get higher and could cause the resident to get dizzy. She said moving forward she will have to focus more when passing her medication and not be distracted. Record review of the facility's Physician Orders policy last reviewed August 2023, it stated that it is the policy of the facility that drugs shall be administered only upon the order of a person duly licensed and authorized to prescribe such drugs and in accordance with the resident's plan of care. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. Record review of the Medication Administration policy, not dated, read in part . it is the policy of this facility to accurately prepare, administer, and document oral medications .take vital signs if required, hold drugs if indicated .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement in that: -Food items were found in the kitchen's cooler with expired and beyond the use by date. -Food items in the walk-in cooler and freezer were not sealed. -Cleaned baking sheets, pans, utensils, and divided platesd had food particles on them. -Menu item on the steam table was not at the correct holding temperature. -The facility failed to ensure that the floor of the dry storage room was free of paper and other debris. These failures could affect residents who ate food from the facility kitchen and place them at risk of food borne illness and disease. Findings included: Observation of the facility's kitchen and interview on [DATE] between 9:30 am and 10:15 am with the Dietary Manager revealed the following: Divided plates with food particles and drinking glasses with white stains were stored with clean divided plates and drinking glasses. Holding pans and baking sheets with food particles in them were stored with clean pans and baking sheets. Serving utensils with dried food particles on them were stored with clean utensils. In the walk in Cooler were three zip lock bags with deli ham open not sealed. There was a bottle of yellow mustard with best used date [DATE]. There was a bottle with tartar sauce with best used date [DATE]. There was a plastic container with Tuna Salad dated ,d+[DATE] -[DATE]. In the walk-in freezer were two boxes: 1 box with Salisbury steak and the other with turkey sausage opened and not sealed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The dry storage room had an accumulation of pieces of plastic, papers, dust, and dirt on the floor . In an interview on [DATE] at 9:55am with the Dietary Manager she said that left over food stored in the cooler should be used within three days. She said she did not know why it was not used by the used date of [DATE]. Further interview with the Dietary Manager on [DATE] at 10:00 am she said the expectation of the staff was to be checking the pans, plates, and utensils to ensure they were cleaned before they were stored. They should sealed open food packages and discard expired food items. She said she was going to ensure the dry storage was cleaned immediately. She said she did not know what happened, why the pans, plates, utensils, baking sheets, and pans were not checked before they were put away. Observation on [DATE] at 12:27 pm of the steam table for lunch revealed one menu item corn dog was 120 degrees Fahrenheit. This menu item was removed from the steam table and reheated to 165 degrees Fahrenheit. In an interview on [DATE] at 12:55pm with the Dietary Manager she said that foods that were off temperature could lead to food borne illness. She said resident could get sick (vomitting and diarrhea) from eating off temperature foods. She said the menu item corn dog was at the correct temperature when it was placed on the steam table. She said she would have to think of a way to ensure that menu items, like corn dogs, maintain the correct holding temperature throughout service. She said she would be in-servicing staff to ensure utensils, pans, pots, plates, and bowls were clean and had no food particles in them before they were stored. Also, they would be in-serviced that hot/cold foods should always be at the correct holding temperature throughout meal service and the poen food packages should be sealed, labeled and dated. The facility presented the Texas Food Establishment Regulations dated [DATE] as the facility policy. The TFER documented in part . Store TCS food at an internal temperature of 41 F (5 C) or lower or 135 F (57 C) or higher. Store frozen food at temperatures that keep it frozen. Make sure storage units have at least one air temperature measuring device. It must be accurate to +/- 3 F or +/- 1.5 C. The U.S. Public Health Service, Food Code, dated 2013, noted the following regarding marking the date of food when prepared and when the original container was opened: ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking 2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under (B) of this section. The Food and Drug Administration Codes [DATE]-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils indicated: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 18 residents (Resident #64) reviewed for medication administration. -The facility failed to ensure that Resident #64's MAR was accurate and complete with no blanks for Levothyroxine (for thyroid dysfunction). This failure could place all resident at risk of not getting medications as ordered by their physicians that could lead to residents not getting the therapeutic effect of their medications. Findings Included: Record review of Resident #64's face sheet dated 11/20/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included acute embolism and thrombosis of right calf (blood clot forming in a blood vessel and break free), skin infection (bacteria, fungus viruses on the skin), hyperparathyroidism (excess of the hormone made by four small gland in the neck), hyperthyroidism (over production of hormone), dysphagia (difficulty swallowing), depressive disorder ((mental disorder) , anxiety (a feeling of worry and fear), psychotic disturbance (mental disorder that causes people to lose touch with reality), and vascular dementia (memory loss). Record review of Resident #64's admission MDS dated [DATE] revealed a BIMs score of 08 indicating resident was moderately impaired for cognition for decision making, for ADL's she was substantial/maximal assistance, and was always incontinent of bowel and occasionally incontinent of bladder. Record review of Resident #64 physician's order dated 10/08/2024 revealed an order for Levothyroxine 25mcg 1 tablet by mouth once a day for thyroid. Record review of Resident #64 MARs for October 2024 and November 2024 revealed there were blanks for 10/31/2024 and 11/18/2024. In an interview on 11/21/2024 at 3:40pm with RN F she stated that there should be no blanks on the MARs. She said when residents were given medications the nurse or medication aide should document ited on the MARs. She said if the resident refused his/her medications it should be documented on the MARs and the reason/reasons why the medication was not given. She looked at the MAR and said thyroid medication, usually would be given by the night staff. She said blanks on the MARs madekes it difficult to determine if the medication was given or not given and the resident could go without their medications or being overdosed if there were blanks on the MARs. In an interview with the DON on 11/21/2024 at 3:50pm she said her expectations ofor nurses and medication aides were to document on the MARs when medications were administered or not administered . Record review of the undated policy and procedure on Medication Administration - Oral read in part . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare	250 W British Flying School Blvd Terrell, TX 75160

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to accurately, prepare, administer, and document oral medication. Record review of the facility's policy/procedure-Nursing Clinical dated 05/2007 read in part . Section: Documentation Subject: Charting and Documentation. Definition of Records: The resident's clinical record is a concise account of treatment, care, and response to care, signs and symptoms and progress of the resident's condition. It is also necessary to include data needed for identification and communication with family and friends. Complete history of resident and present illness is required under current law and regulations at the time of admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678 Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #10) of 1 resident observed for wound care. RN A failed to properly wash or sanitize his hands after changing his gloves when providing wound care to Resident #10. This deficient practice placed 18 residents who received wound care at risk for cross contamination and/or spread of infection. Findings included: Record review of Resident #10's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves), muscle weakness, metabolic encephalopathy (a group of neurological disorders that occur when the brain is affected by a chemical imbalance in the blood), need for assistance with personal care, Felty's syndrome (a rare complication of rheumatoid arthritis characterized by an enlarged spleen and low white blood cell count), contracture of the right hand, and contracture of the left hand. Record review of Resident #10's comprehensive care plan, dated 10/2/24, indicated Resident #10 had wounds on right medial buttocks-hydrocolloid and left medial sacrum-hydrocolloid and was receiving treatment for his wounds. Record review of the quarterly MDS dated [DATE] indicated Resident #10 had a BIMS of 15 which indicated cognition was intact. The MDS indicated Resident #10 was at risk of developing pressure ulcers/injuries. Resident #10 required skin treatments that used applications of nonsurgical dressings and applications of ointments/medication. Record review of physician orders dated 11/21/24 indicated Resident #10 had an order for non-pressure wound to left medial sacrum, apply triad paste every day and night shift. Resident #10 also had an order for non-pressure wound to right buttock, apply triad paste every day and night shift. Observation on 11/20/24 at 11:38 am, revealed RN A and ADON A assisted Resident #10 with wound care. Resident #10 was lying in bed on pressure relief mattress on his back. Further observation of wound revealed unstageable wound to right upper buttock and left medial buttock. ADON A said the wound was in-house acquired due to shearing while moving the resident in bed. RN A prepared set-up treatment dressing at Resident #10's bed side table, using 4x4 gauzes he cleaned the left medial buttock twice, then changed gloves without washing hands or using hand sanitizer. RN A put on clean gloves, picked up wet 4x4 gauzes soaked in normal saline and cleaned right upper buttock wound twice, changed gloves without washing hands or using hand sanitizer. RN A donned clean gloves, scoop Triad Hydrophilic wound dressing Hydrophile cream applied to right upper buttock and left medial buttock and then placed a clean brief on resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADON A on 11/20/24 at 11:54 am, regarding Resident #10's wound care, she stated RN A did not use hand sanitizer or wash hands after he changed gloves. Interview with RN A on 11/20/24 at 12:00 pm, he said he was very nervous, and he knew he could spread infection if he did not perform hand washing . Interview with ADON A on 11/21/24 at 10:00 am she said the expectation when nurse's perform wound care was to follow infection control protocols, make sure orders were followed, assess resident for pain and new wounds, and report changes. ADON A said the facility had an in-service on infection control earlier that week. She said the risk to the resident was it could potentially introduce new infections. Interview with DON on 11//21/24 at 10:20 am she said the expectation for staff when they provide care was to wash their hands after changing gloves. She said the facility had many in-services on infection control. She said the risk to the resident was possible infection. Record review of the facility's Infection Control policy dated 7/20/22 read in part . it is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . standard precautions include gloves are worn when contact with blood, body fluids, mucous membranes, non-intact skin, or potentially contaminated surfaces or equipment are anticipated, and hand hygiene . Review of the CDC website on 10/22/24: https://www/cdc.gov/clean-hands/hcp/clinical-safety/index.html indicated: Know when to clean your hands- immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient, after touching patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces, immediately after glove removal. The facility provided a weekly skin assessment list of residents with wounds dated 11/13/24 and revealed 18 residents received wound care.